SEAL BEACH PHYSICAL THERAPY

PLEASE PRINT LEGIBLY

PATIENT INFORMATION

☐New Patient ☐New Diagnosis
☐Returning Patient ☐New Insurance

Name (Last, First, Middle Initial)

Address City/State/Zip

(____)______________(_____)______________
Home/Cell Phone Cell/Work Phone

E-mail address

☐ I would like to receive reminders and receipts via text message.
☐ I would like to receive reminders and receipts via email.

_____-____-_____ ___/___/___ ______________
Social Security # DOB Driver License #

Referring Physician Treating Therapist

☐M ☐F
Marital Status Employment Status Sex

Occupation Employer

Address City/State/Zip

EMERGENCY CONTACT INFORMATION

Emergency Contact Name (Last, First)

(_____)______________ (______)______________
Home/Cell Phone Work Phone

Address City/State/Zip

Relationship to Patient

FINANCIALLY RESPONSIBLE PARTY

Name (Last, First, Middle Initial)

Address City/State/Zip

(_____)______________ (______)______________
Home/Cell Phone Work Phone

☐M ☐F
Relationship to Patient Sex

E-mail address

____-_____-______ ____/____/____ ______________
Social Security # DOB Driver's License #

I ATTEST THAT I AM NOT CURRENTLY RECEIVING HOME HEALTH CARE (HHC) FOR ANY REASON. I WILL NOTIFY SEAL BEACH PHYSICAL THERAPY IF I BEGIN TO RECEIVE HHC (I.E. MEDICARE PART A)

___________ **(PATIENT INITIALS)**

EQUIPMENT SUPPLY POLICY

YOUR THERAPIST **MAY** RECOMMEND ELECTRICAL STIMULATION TO ASSIST IN YOUR TREATMENT. THERE IS A ONE-TIME SUPPLY FEE OF $10 FOR A NEW SET OF ELECTRODES, AS YOUR INSURANCE COMPANY DOES NOT COVER THIS FEE. THESE ELECTRODES WILL **ONLY** BE USED FOR YOUR CARE. YOU MAY REFUSE THIS TREATMENT AT YOUR SOLE DISCRETION. I ACKNOWLEDGE THIS CHARGE AND AGREE TO PAY AT THE TIME OF SERVICE. ______________________ **(SIGNATURE)**

Patient Consent and Payment Agreement for Services Rendered

This is a contract entered into on _______________ (Date) by Seal Beach Physical Therapy, Inc (hereinafter referred to either as "SBPT" or "Provider") and _________________________, an individual (hereinafter referred to as the "Patient")

A. **Patient/Provider Relationship.** Patient understands that it is Patient's full responsibility to have obtained any and all necessary referrals and authorizations required prior to treatment by SBPT. If Patient's insurance company requires a referral and Patient does not have one, then Patient understands and acknowledges that Patient will be responsible for the entire bill for rendered services. As such, Patient represents that the Patient has presented a physician's order, prescription, and/or a written referral, if applicable, to engage Provider to perform physical therapy services, including but not limited to: an Initial Evaluation of the Patient's injuries and therapeutic modalities including but not limited to joint manipulation, guided therapeutic exercises, guided functional exercises, neuromuscular re-education, therapeutic activities, gait training, Astym therapy, ice, heat, electrical stimulation, and/or taping. Additionally, re-evaluations may be performed to assess the Patient's progress working towards desired outcomes. Patient acknowledges that No promises or guarantees have been made as to the results or outcomes of these treatments or modalities. SBPT hereby agrees to provide the Patient with such services in exchange for full payment of all financial consideration as described herein.

B. **Benefit Coverage.** A quote of benefits from your insurance carrier is **NOT** a guarantee of coverage. Therefore, SBPT is **NOT** responsible for inaccurate information provided by, to, or through your insurance company. **It is solely your responsibility to call your carrier to determine and confirm your coverage** ("Benefits") **and confirm that SBPT is a participating provider under Patient's Coverage**. For clarification, your insurance plan ("Coverage") is a contract between *you* and your carrier, **Not** SBPT. Therefore, Patient understands that per Patient's insurance policy and the terms of this Agreement that Patient's Coverage may **not** cover 100% of Patient's bills for services provided, and as such, Patient acknowledges that Patient is financially responsible for any and all charges not covered by Patient's insurance, including any charges resulting from a misquote of Benefits or misunderstanding of Coverage.

In the event that Patient fails to provide all necessary and current insurance information, Patient understands that Patient's insurance company (ies) may deny payment of claims relating to services rendered to Patient by SBPT. As such, Patient fully understands and accepts that if such denial occurs, Patient will still be fully responsible for any and all outstanding balances with SBPT.

If the Patient is a minor, the parent/guardian hereby accepts all financial responsibility for all charges and/or fees not covered by insurance as previously stated.

Based on the information provided to us from your carrier, the **ESTIMATED** cost per treatment includes, but is not limited to co-pays and coinsurance, cost of services rendered, supplies and equipment, and are due, in full at time of service as shown and initialed by responsible party. I certify that I know my eligibility and benefits as stated on my insurance verification: __________ (**Initial**)

(BY INITIALING THIS SECTION, YOU ACKNOWLEDGE THIS INFORMATION IS AN ESTIMATE OF BENEFITS AND NOT A GUARANTEE OF PAYMENT. YOU ARE RESPONSIBLE FOR ALL TREATMENT RELATED FEES BASED ON YOUR CONTRACTUAL AGREEMENT WITH YOUR INSURANCE COMPANY EVEN IF THE EVENT YOUR BENEFITS WERE MISQUOTED TO US)

C. **Payment for Services.** Patient shall be fully responsible for all payments of services, including but not limited to deductible, co-insurance, co-payments, equipment, supplies, and charges not paid for, whether in part or in whole, by insurance per Patient's insurance benefits. Patient's total unpaid balance for all services, deductible, co-insurance, co-pay amounts, and any unpaid equipment and supply charges (not paid at the time of issue) are subject to SBPT's collection policy. SBPT's policy is: All insurance responsible claims must be paid in full within Sixty (60) days following the date your insurance company receives a clean claim. Upon claim processing, and starting the 61^{s} day from the first statement date, should the Patient or legally designated representative fail to pay SBPT the full amount due per SBPT's policy, a late fee equal to ten percent (10%) of the amount due shall be added to the claim balance. Additionally, starting on the 61st day the claim is outstanding until the debt is fully settled, interest shall accrue on all past-due amounts at ten percent (10%) per annum (compounded monthly). In the event of an over-payment, SBPT shall have thirty (30) days following the posting of the applicable processed claim to refund the over-payment.

D. **Credit Card Authorization.** In the event the open claim balance has not been satisfied on the sixty first (61st) day from submission to the insurance company, or in the event any check used for payment by Patient is returned or declined due to insufficient funds, SBPT is hereby authorized to charge my credit card on file in an amount equal to the full open claim balance. All approved written payment plans are null and void if your Credit Card payment is not approved and payment cannot be collected within twenty-four (24) hours via valid Credit Card __________ (**Initial**)

Deductibles, co-pays, co-insurance, equipment, and supplies ARE DUE IN FULL AT THE TIME OF SERVICE. As a courtesy to you, we can automatically charge your card the estimated patient responsibility for each visit based on the estimated benefits quoted by your insurance company. Please acknowledge by initialing that you authorize Seal Beach to charge your credit card on file for each date of service, unless other payment arrangements have been made. __________ (**Initial**)

Once your claims have processed we can determine your exact responsibility. Necessary adjustments to the amount due will then be made. If an overpayment has been made, you will be promptly refunded. Additionally, we will use your credit card to process any cancellation or no-show fees. If you prefer to provide alternate payment or slide your credit card at every appointment, we will then only use your credit card on file to satisfy any remaining fees due after claims processing, at the end of your treatment or on the 61st day from submission to the insurance company, whichever is sooner. All approved written payment plans are void if your Credit Card payment is not approved and payment cannot be collected within twenty-four (24) hours via valid Credit Card. In the event there is no credit card on file, Patient acknowledges they may be discharged from care of the provider until such time as Patient's account is brought current.

E. Patient Discharge/Collections Fees. In the event Patient fails to pay for services rendered, Patient understands that Patient may be discharged from the services of Provider until such time as Patient's account is paid in full. Additionally, Patient understands that Patient may be referred to a collections agency for non-payment of fees due for services rendered by Provider. Patient understands and agrees that Patient will be responsible for all collection, agency, and/or attorneys' fees, as well as all costs associated with the collection process (including but not limited to Court costs), and that these fees and costs will be added to Patient's account balance. Moreover, Patient understands and expressly agrees that Patient's Personal Health Information ("PHI"), as regulated by HIPAA, may be revealed in an effort to collect all past due outstanding balances.

F. Returned Check Fee. Patient understands that in the event a check used for payment is returned due to insufficient funds, Patient agrees to provide, within twenty-four (24) hours of notice, cash, money order, or certified check for the full amount of the payment owed, in addition to a $45.00 returned check charge. If Patient makes no secondary payment per the terms herein, then Patient hereby authorizes Provider to charge Patient's Credit Card the outstanding amount per the terms of Section "E," hereto.

G. Assignment of Benefits. Patient hereby authorizes assignment and/or payment of all Benefits, which are payable to Patient under the terms of Patient's Coverage, to be assigned and/or paid directly to SBPT for services rendered, as provided by California State and/or federal prompt pay rules, regulations, and statutes. Patient further consents to the use and disclosure of PHI or any other relevant personal information for the purposes of treatment, payment, and general operations, including but not limited to the processing of all insurance claims. SBPT courtesy billing service is limited to billing primary and secondary insurance carriers, all other insurance claims are the patient's responsibility to file. I understand I am responsible for any costs incurred by SBPT to adjudicate my claims. Lastly, I understand that I, my heirs and/or assignees are fully responsible for any outstanding charges, including charges for equipment and supplies not paid by my insurance.

Patient understand that should Patient's insurance company send payment directly to Patient, Patient will either immediately forward the actual checks, endorsed to SBPT, Inc., or provide SBPT the exact amount of the insurance payment by check or cash within seven (7) days of Patient having received such insurance payment, which hereby belongs to SBPT. Patient agrees that in the event Patient fails to satisfy claim balance(s) upon cashing any applicable insurance checks, the claim balance(s) can be paid by credit card, subject to the terms of Section E, hereto. Patient hereby authorizes SBPT to charge the credit card on file in the amount necessary to satisfy the entire unpaid claims balances including a three percent (3%) pass-through credit card service fee. __________ **(Initial)**
Note: Cashing check(s) with the intention of defrauding SBPT may be considered a crime

H. Missed Appointment Fee. I understand that I will be assessed a $50 fee if I miss a scheduled appointment without having provided a twenty-four (24) hour advance notice of cancellation. We understand that from time to time there may have circumstance that require you to cancel with less than 24 hours' notice. We will determine the fee assessment on a cases by case basis. Because we do not over book, giving us as much notice as possible allows us to try to fill your appointment, thereby simply allowing us to waive your fee. "No-Showing" will ALWAYS result in a missed appointment fee assessment. __________ **(Initial)**

I. **Out-of Network Responsibilities**. SBPT agrees to accept the amount paid for claim reimbursement when the insurance payer considers SBPT an "Out of Network Provider," so long as the amount paid is accurate payment for the services rendered. **Further, the Patient's Out-of-Pocket financial responsibility to SBPT will be limited to the amount equal of what would be the Patient's financial responsibility for In-Network providers**.

J. This contract shall be governed by the laws of the County of Orange in the State of California and all applicable federal laws.

Patient Information Consent Form

I have read and fully understand Seal Beach Physical Therapy, Inc.'s (SBPT) "Notice of Information Practices." I acknowledge that the Health Insurance Portability Act (HIPPA) Notice of Privacy has been made available to me. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that SBPT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in SBPT "Notice of Information Practices" I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.__________ **(Initial)**

Understanding "Orthopedic Manual Physical Therapy"

The licensed clinical staff at SBPT is trained in "manual therapy" techniques that are considered part of "orthopedic manual physical therapy." These and other traditional therapy activities, including electrical and hot/cold modalities and exercises will be implemented during your therapy. Use of "manual therapy" techniques imply physical contact is likely to occur between the therapist's hands and the body of the patient. In some cases the techniques require close contact to safely perform the technique(s) correctly. We recognize this may be your first experience with physical therapy and the process may initially be unfamiliar. We will do our very best to explain the technique(s) to you. **Please notify your therapist if you have questions about a particular technique, as we may be able to adjust the technique or change to a different technique to accomplish the desired intent.** I acknowledge I have read and understand the above information. __________ **(Initial)**

"Open" Environment Treatment Setting Consent

At SBPT we understand your privacy is important. We have take action necessary and reasonably to protect your rights and Private Health Information (PHI). your experience however may differ from previous physical therapy and doctor's office experiences. For your protection and that of the therapists, our clinic is set up to treat patients in an "open" environment where incidental exposure of PHI may occur from time-to-time. our extensive experience treating patients in this exact environment suggests it is a supportive setting fostering interaction and shared experience(s) with other patients. These experiences often set a positive tone facilitating recovery and ultimately improving the quality of your care. Furthermore, this setting allows your therapist to interact with and monitor you and your progress at all times. We realize however some patients may not be entirely comfortable with this setting. If you require or prefer a private room for your exam and/or follow up treatment, we encourage you to discuss your request with your therapist **prior to your examination** and we will do everything reasonably possible to accommodate your needs, your treatment and our conduct toward you will be equivalent, regardless of the choice you make on this matter. If you do not inform the therapist, he/she will assume you are agreeable with the "open" environment setting.

If you feel the management of your request has been inappropriate, please discuss your experience with the clinical director by Calling Brandon Dederich at (805) 551-6677.

I have carefully read the above statement and understand that incidental PHI may be exposed to other patients being treated in the clinic simultaneously. I also understand that I retain the right to request a private room by notifying the therapist or receptionist before the initial exam or follow up treatment.

______________________	______________________	__________
Patient Signature	**Patient Name (Please Print)**	**Date**

In witness of their agreement to the terms above, the parties or their authorized agents hereby affix their signatures:

("Patient")	("SBPT" or "Provider")
______________________________	______________________________
(Signature of Patient or Authorized Representative)	(Signature of Provider or Authorized Agent)
______________________________	______________________________
(Print name of Patient/Authorized Representative)	(Printed Name of Provider or Authorized Agent)
________________	________________
(Date)	(Date)

Credit Card Authorization Form

Initial Evaluation: $_____ Follow Ups: $______

Please Print Legibly

Credit Card: □ Visa □ MasterCard □ Discover □ Amex
(Debit cards can be used if they have a major credit card logo.)

Patient's Name: ______________________________

Name on Card: ______________________________ Card #:____________________________________

Expiration: ___/___/____ Security Code: _________ (3 digits on back of card)

Billing Address: ____

City, State, ZIP Code: ____

Email for receipt: ____

Cardholder Signature: ____ Date: _______________

PLEASE PRINT LEGIBLY

INJURY INFORMATION

______/______/______ Date of Injury or symptoms

☐Yes ☐No Did you have surgery?

______/______/______ Date of Surgery

______________________________ Surgical Procedure

☐Yes ☐No Were you in a car accident?

______/______/______ Date of accident

☐Yes ☐No Were you injured at work?

☐Yes ☐No Is litigation involved?

____ If yes, what is your attorney's name and phone number?

____ Have you had physical therapy for this condition before?

☐Yes ☐No If yes, did it help?

____ Please describe the injury.

____

What activities/movements cause your symptoms? What activities are most affected by your condition?

____

What would you like to achieve through your physical therapy care?

MEDICAL HISTORY

(Past and Current)

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		Allergies			Emphysema			Pacemaker
		Anemia			Fractures			Parkinsons
		Anxiety			Gallbladder Problems			Pulminary Disease
		Arthritis			Heart Disease			Rheumatoid Arthritis
		Asthma			Hepatitis			Seizures
		Cancer			High Blood Pressure			Smoking
		Chemical Dependency			Incontinence			Speech Problems
		Circulation Problems			Kidney Problems			Strokes
		Currently Pregnant			Metal Implants			Thyroid Disease
		Depression			Multiple Sclerosis			Tuberculosis
		Diabetes			Osteoporosis			Vision Problems
		Dizzy Spells						

Do you have any other medical conditions or diagnoses of which we should be aware? If yes, please describe:

____

Have you ever had surgery? If so, please describe the procedure below, including the month and year of the operation.

____

Please describe your recreational activities: ____

____ **Patient Signature (Parent/Guardian if patient is a minor)**

____ **Patient Name (Last, First)**

PLEASE PRINT LEGIBLY

MEDICATION LIST

Please list all medications you take including name, dosage, and the frequency you take it.

____

____

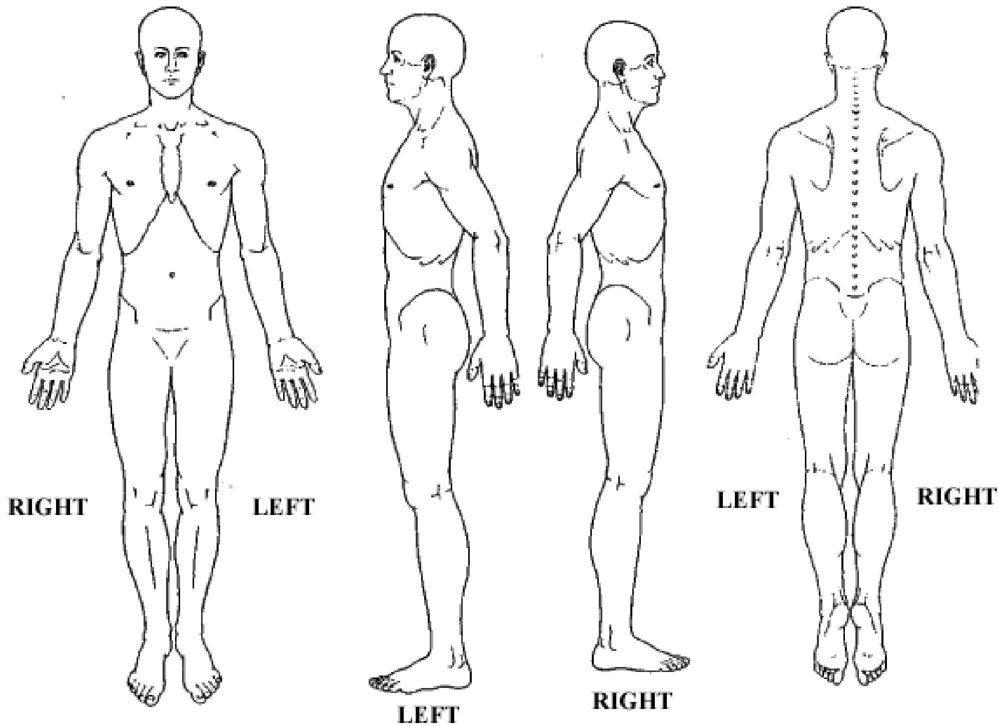
____

____

PAIN LOCATOR

Using the figures below, please mark the areas where you feel the described sensation on your body. Please use the following symbols to describe all the affected areas. Please be as specific as possible.

NNN	Where you experience Numbness	TTT	Where you experience Tingling or Pins & Needles
BBB	Where you experience Burning	XXX	Where you experience Stabbing or Aching Pains



Please rate your average level of pain on a scale of 0-10. "0" equals no pain, and "10" equals the most severe pain you could ever imagine. Please mark your level of pain on the body next to each affected body part.

____
Patient Signature

____ ________/________/________
Patient Name (Please Print) **Date**

Note: Patient must sign and date this page in his or her own handwriting. Thank you.

Social Media Informed Consent

Seal Beach Physical Therapy is pleased to participate in social media outlets such as Instagram, Facebook, Twitter, etc. Through these platforms, we share staff pictures, treatment modalities, exercises, and office updates. With the permission of our patients, we are pleased to share posts welcoming new patients to our clinic, demonstrating various exercises and treatment modalities.

I hereby give Seal Beach Physical Therapy, and any and all employees of Seal Beach Physical Therapy, the right and permission to publish photographs and/ or videos of me for promotional and marketing purposes including but not limited to, advertising, publicity, or display of use. I also authorize my photos and/ or videos to be posted on social media, such as Instagram, Facebook, Twitter, and the office's website page.

- ❏ I give my consent to allow Seal Beach Physical Therapy the ownership and right to post photographs or videos of me/my child on social media
- ❏ I do not give my consent to take photographs or videos of me/my child.

____
Name of Patient

____ ______________
Signature of Patient or Responsible Party Date

How did you hear about us? (check all that apply)

- ❏ Doctor
- ❏ Family / Friend
- ❏ Insurance Company
- ❏ Internet
  - ❏ Website
  - ❏ Google
  - ❏ Instagram
  - ❏ Facebook
  - ❏ Yelp
- ❏ School
- ❏ Other ____________________________